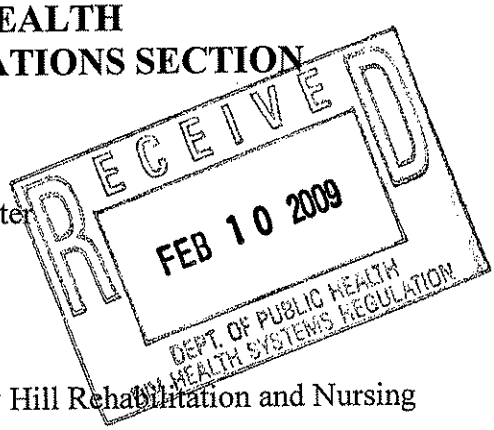
STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION



IN RE: Norwalk Health Care, Inc of Norwalk, CT
d/b/a Honey Hill Rehabilitation and Nursing Center
34 Midrocks Road
Norwalk, CT 06851

CONSENT ORDER

WHEREAS, Norwalk Health Care Inc, of Norwalk d/b/a Honey Hill Rehabilitation and Nursing Center (hereinafter the "Licensee"), has been issued License No. 2116-C to operate a Chronic and Convalescent Nursing Home known as Honey Hill Rehabilitation and Nursing Center (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on September 2, 2008 and concluding on September 19, 2008; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated October 22, 2008 (Exhibit A – copy attached); and

WHEREAS, a conference regarding the October 22, 2008 violation letter was held between the Department and the Licensee on November 5, 2008; and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Geoffrey F. Cole its President, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent

Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the INC.

2. The INC shall function in accordance with the FLIS' INC Guidelines (Exhibit B - copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
3. The INC shall provide consulting services for a minimum of six (6) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility thirty-two (32) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the six (6) month period and may, in its discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.
4. The INC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
5. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks of assuming the position of INC.
6. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, Medical Director and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.
7. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct patient care in the facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with

the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.

8. The INC shall submit weekly written reports to the Department documenting:
   a. The INC's assessment of the care and services provided to patients;
   b. The Licensee's compliance with applicable federal and state statutes and regulations; and
   c. Any recommendations made by the INC and the Licensee's response to implementation of the recommendations.
9. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
10. The INC shall have the responsibility for:
    a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
    b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
    c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and
    d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated October 22, 2008 (Exhibit A).
11. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet or have telephone conferences with the Department every six (6) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at twelve (12) week intervals throughout the tenure of the INC. The meetings or telephone conferences shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

12. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.
13. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
14. Within fourteen (14) days of the execution of this Consent Order the Director of Nurses shall develop and/or review and revise, as necessary, policies and procedures related to physical assessment of patients with pressure ulcers, pressure ulcer prevention and treatment, documentation and tracking of pressure ulcers, care planning, interventions pertinent to pressure ulcers, and turning and repositioning of patients.
15. Within twenty-one (21) days of the effect of the Consent Order all Facility nursing staff shall be inserviced, to the policies and procedures identified in paragraph number fourteen (14).
16. The Facility shall contract with a credentialed Wound Care RN. The certified Wound Care RN shall serve a minimum of twenty (20) hours a week for a six (6) month period and shall conduct staff training, provide oversight to nursing staff regarding the assessment, monitoring and treatment of pressure sores, maintain weekly statistics, observe all pressure sores, monitor preventative protocols and assess patients at risk for pressure sores and/or vascular sores and/or other wounds.
17. The Department shall retain the authority to extend the period of the certified Wound Care RN functions are required, should the Department determine that the Facility is not able to maintain substantial compliance with federal and state laws and regulations pertinent to pressure ulcers. Examples of violations which may cause the Department to invoke this provision include, but are not limited to, failure to notify the physician of a significant change in skin condition, and/or failure to provide care and treatment to patients identified with skin integrity issues and/or failure to implement physician orders. Determination of compliance with federal and state laws and regulations will be based upon findings identified during onsite inspections by the Department.

18. The certified Wound Care RN contracted to provide wound care oversight shall provide a bi-weekly report to the Department regarding his/her responsibilities and an assessment of the Facility's progress as related to issues of skin integrity.
19. The certified Wound Care RN shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
20. The Facility's medical staff shall review all policies and procedures related to skin integrity. Each primary care physician shall examine their patients relative to impaired skin integrity and document the results of the examination at the time of each visit..
21. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:
    a. Sufficient nursing personnel are available to meet the needs of the patients;
    b. Patients are maintained, clean, comfortable and well groomed;
    c. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
    d. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;
    e. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
    f. Nurse aide assignments accurately reflect patient needs;
    g. Each patient's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
    h. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified;

i. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;

j. Necessary supervision and assistive devices are provided to prevent accidents;

k. Policies and procedures related to dehydration prevention are reviewed and revised to include, in part, notification of the attending physician or medical director when the patient's fluid intake does not meet their assessed needs; and

l. Patient injuries of unknown origin are thoroughly investigated, tracked, and monitored.

22. Effective upon the execution of this Consent Order, the Licensee shall appoint a free floating Registered Nurse Supervisor on each shift whose primary responsibility is the assessment of patients and the care provided by nursing staff. A nurse supervisor shall maintain a record of any patient related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Such records shall be made available to the Department upon request and shall be retained for a two(2) year period.

23. Individuals appointed as Nurse Supervisor shall be employed by the facility, shall not carry a patient assignment and shall have previous experience in a supervisory role.

24. Nurse Supervisors shall be provided with the following:

a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;

b. A training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;

c. Nurse Supervisors shall be supervised and monitored by a representative of the Licensee's Administrative Staff, (e.g. Director of Nursing Service or Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for the Department's review; and

d. Nurse Supervisors shall be responsible for ensuring that all care is provided to reside patients by all caregivers is in accordance with individual comprehensive care plans and that staff receive remediation when they fail to perform in accordance with facility policy or standards of practice.

25. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.

26. The Licensee shall review its Quality Assurance Program (QAP) to identify why the program failed to identify the quality of care issues identified in the violation letter dated October 22, 2008. The members of the QAP shall meet at least monthly to review and address the quality of care provided to patients and, if applicable, implement remediation measures that shall provide identification of issues in a timely manner. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.

27. In accordance with Connecticut General Statute Sections 19a-494 (4) and 19a-494 (7) the Commissioner of the Department of Public Health hereby issues a reprimand to the Licensee and orders the Licensee to comply with all statutory and regulatory requirements pertaining to the operation of a chronic and convalescent nursing home.

28. The Licensee shall pay a monetary penalty to the Department in the amount of six thousand dollars ($6,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within two (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Barbara A. Yard
Health Program Supervisor
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

29. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be

construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

30. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
31. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
32. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
33. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order the Department retains the right to issue charges including those identified in the October 22, 2008, violation letter referenced in this document.
34. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

Norwalk Health Care, Inc of Norwalk, CT d/b/a
Honey Hill Rehabilitation and Nursing Center
of Norwalk, CT

Feb. 5th, 2009
Date

By: Geoffrey F. Cole
Geoffrey F. Cole, President

STATE OF Connecticut)

County of Fairfield) ss February 5th 2009

Personally appeared the above named Geoffrey F. Cole and made oath to the truth of the statements contained herein.

My Commission Expires: 4/30/2012
(If Notary Public)

Mercedes Rice

Notary Public	[✓]
Justice of the Peace	[ ]
Town Clerk	[ ]
Commissioner of the Superior Court	[ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

2/11/09
Date

By: Joan D Leavitt
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 34

October 22, 2008

Mr. Arthur Santilli, Administrator
Honey Hill Care Center
34 Midrocks Drive
Norwalk, CT 06851

Dear Mr. Santilli:

Unannounced visits were made to Honey Hill Care Center which concluded on September 19, 2008 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a certification inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for November 5, 2008 at 1:30 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Rosella Crowley, RN/MMC

Rosella Crowley, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

RAC/RH:jpf

c. Director of Nurses
Medical Dirctor
President

Complaints #CT8473 and #CT7206

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(L).

1. Based on clinical record reviews, review of the acute care record, observations, and interviews for 3 of 6 sampled residents admitted with wounds (surgical and/or other wounds) (R#312, 500, 309), the facility failed to immediately notify the resident's physician of the presence of wounds and obtain treatment orders, and/or failed to transcribe/obtain approval for treatments that were directed on the resident's hospital transfer documentation, and/or failed to notify the physician when a new treatment order was needed. The findings include:
   a. Resident #500 was admitted to the facility on 8/29/08 after hospitalization for osteomyelitis. Other diagnoses included end stage renal failure requiring hemodialysis. The hospital discharge summary identified the presence of a "skin tear" measuring 1.5 by 1 cm on the right sacrum. A physician note included with the hospital discharge summary dated 8/26/08 identified the presence of a stage II pressure sore of the sacrum. Admission physician orders dated 8/29/08 directed skin treatment to buttock with "TAO with Telfa dressing daily". The admission nursing assessment dated 8/29/08 identified the presence of a 1 by 1 cm "skin tear" and indicated the location was on the right upper buttock/sacral area. A non-pressure sore skin condition report indicated the presence of a 1 by 1 cm "skin tear" on the right upper buttock on 8/29/08. The treatment kardex for September 2008 was reviewed and noted that the treatment had been circled indicating it was not done from 9/4-9/10/08. The reason for lack of treatment was not documented on either the kardex or in the nurse's notes. Observations with the ADNS on 9/11/08 at 1:40 PM noted a quarter sized circular wound on the right upper sacrum that was covered with pink, fragile tissue. The surrounding skin was noted to be dark red in color. The resident noted at the time that the area still hurt although hurt less than before. The resident also noted that the dressing that had been being applied would not stay on and no one had tried applying anything else. No dressing was present on the wound and the resident noted that no other treatments had been applied. The ADNS noted at that time that the area was a pressure sore that was fragile and required ongoing treatment. She further noted that although she was the wound nurse, she had not been notified of the wound because it had been classified as a skin tear. Review of the clinical record failed to provide evidence that the physician was notified of the treatment failure,or that another form of protection/treatment had been initiated.
   b. Resident #309 was admitted to the facility on 8/29/08. He/she was hospitalized with diagnoses that included failure to thrive, anasarca, dehydration, diabetes, and venous insufficiency. The inter-agency referral (W-10) and hospital discharge summary indicated the presence of non-pressure ulcers on the left heel and right calf. Treatment directions indicated that both lower extremities were to be treated with Maxsorb Ag dressings daily along with leg elevation. Admission physician orders dated 8/29/08 failed to direct any treatments to the lower extremities except for the application of Ammonium Lactate 12% to both feet twice a day for 2 weeks. The admission nursing assessment indicated the presence of a thick crust to both lower extremities front and back and an area on the right posterior

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

calf that was crusted with drainage. No measurements or other descriptions of the area were indicated. No further assessments/descriptions of the legs were noted in the clinical record until the PA assessed the resident on 9/8/08. The PA assessment noted only the presence of "chronic hyperpigmentation" and dry, thick skin to the lower extremities; unable to palpate pedal pulses. Also noted was chronic venous insufficiency, and peripheral vascular disease. Orders were written at that time to treat the right lower extremity with Alginate and a non-adherent dressing daily and to apply Aquaphor to both lower extremities every shift. No descriptions/assessments of the lower extremities were noted in the clinical record. Observations on 9/11/08 at 1:40 PM noted both legs were edematous and the skin was thick, crusty, and splitting in some areas. When the resident pulled up the pant legs, a large (greater than ½ dollar sized), red open area was noted below the right knee that was not covered by a dressing. Dry drainage was noted down the leg to just above the ankle area dressing. The resident noted it had been oozing "like mad".

The ADNS attempted to remove the dressing, but the dressing was firmly adhered to the skin. After soaking off the gauze covering the wound, a large, raised, white, macerated ulcer area was noted on the back of the right lower leg just above the ankle. The ADNS noted that she had not assessed the areas prior to this time and would call the physician for orders to treat the new open area. Review of the clinical record with the ADNS at that time failed to provide evidence that the treatment orders listed on the hospital transfer summary for both lower extremities had been transcribed and/or that the physician had been notified of the wounds and need for treatment orders from admission on 8/28/08 through 9/8/08.

Resident #312 was admitted to the facility on 9/11/07 after sustaining a fall with a tibia-fibula fracture of the left ankle. The resident had an external fixation device applied to stabilize the fracture on 7/24/07. The resident was admitted to the hospital on 8/3/07 where he/she underwent removal of the fixation device and internal fixation repair of the fracture. The postoperative period was complicated by metabolic encephalopathy and deep vein thrombosis. The resident was transferred to another hospital on 8/17/07 for acute inpatient rehabilitation and discharged to the skilled nursing facility on 9/11/07 for further rehabilitation. The W-10 and discharge summary from the hospital dated 9/11/07 indicated the presence of a splint to the left lower extremity that was wrapped with an ace wrap and a left heel "abrasion" that was covered with a "Biatain" dressing. Admission physician telephone orders dated 9/11/07 failed to direct any treatment to the left heel or directions for removing/not removing the splint to the left leg. The admission nursing assessment dated 9/11/07 identified the presence of a splint made of cast material to the left lower extremity. The toes were warm to touch and circulation, sensation, and movement were positive. No further assessment of the skin was completed at that time. Nurse's notes dated 9/13/07 on the day shift indicated that sutures were present to the left outer ankle. The note indicated that there was a broken suture and an open area in the incision line. The note indicated that the issue was put on the board for APRN assessment, the area was cleansed and a dressing applied. The physician was not notified and no treatment orders obtained at that time. No further mention of the area was noted in the clinical record until 9/17/07 when the APRN first assessed the area. The APRN assessment noted that the left outer ankle suture site was draining, that the son reported that the sutures needed to come out (still in place from the

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

August surgical repair), and that she was not sure where the bleeding was coming from. She noted that an ace wrap was in place over a soft partial cast, and that the resident was experiencing pain on a scale of 10/10 that would reduce to 8/10 after Tylenol (the only pain medication ordered for the resident). The APRN then faxed written recommendations to the attending physician who had not yet visited/assessed the resident at the facility. The recommendations included:

1. Alleve twice a day for pain
2. Obtain x-ray of the left ankle/tibia/fibula.
3. Possibly have nursing or APRN unwrap Kling, clean and inspect wound to identify site of bleeding.
4. Remove as many sutures as possible.
5. Questionably have APRN check resident ' s PT/INR with machine approved by medical board (had not had PT/INR and was on Coumadin)

No phone call was documented and the physician failed to respond to the fax request.
On 9/17/07 at 4 PM the resident's blood sugar was noted to be 356 mg/dl. Coverage was administered as ordered with 10 units of Regular Insulin. A blood sugar recheck at 8 PM noted a blood sugar of 400 mg/dl. No nurse ' s note was documented for the 3-11 PM shift, however physician orders at 8PM directed to administer 12 units of regular insulin at that time and to obtain labs including CBC, chemistry, and urine for culture and sensitivity. No vital signs were documented. No night shift note was present in the clinical record. On 9/18/08 the 7 AM-3 PM shift documented that the resident's appetite was poor. No vital signs were documented. The 3 -11 PM shift note indicated that the resident's urinalysis showed 2+ leukocytes and the report was "faxed" to the attending physician.
On 9/19/07, at 4 PM, the resident was noted with a temperature of 102 degrees Farenheit and a blood sugar of 389 mg/dl. The physician was notified at that time of the temperature and the positive urinalysis report and ordered the administration of Cipro. Laboratory results reported to the facility on 9/19/07 were notable for a BUN of 56 (normal 6-25), Creatinine of 2.2 (normal 0.67-1.17), and a white count of 13.1 (normal 3.8-10.6). The abnormal laboratory results were faxed to the attending physician and no response or follow up call was noted in the clinical record or 24 hour reports.
On 9/20/07, the resident's 6 AM blood sugar was 476; the physician was notified and regular insulin coverage ordered. No further assessment or vital signs were documented. At 8 AM, the resident went for a consult with a local orthopedist. Review of the acute care record noted that from the physician's office, the resident was sent directly to the hospital and admitted with diagnoses of osteomyelitis of the left lower extremity, sepsis (positive blood cultures were obtained on admission for staph aureus), and dehydration with a BUN of 65. The resident underwent immediate open amputation of the left leg below the knee.
Interview and review of the clinical record with the DNS and Unit Manager on 9/5/08 at 8 AM failed to provide evidence that the treatment to the left heel had been transcribed on admission as per the W-10, and/or that the physician had been notified and/or the medical director when drainage and sutures along with an open area were noted on the left ankle on 9/13/07 and again on 9/17/07.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Subsequent to surveyor inquiry, the DNS found a paper in her desk dated 9/21/07 by the evening supervisor that noted she had removed the splint and dressings on 9/17/07. The note indicated that an open area in suture line of the ankle appeared to be the source of bleeding and that the resident had a 4 by 5 cm area of dark eschar on the left heel that the resident's son reported at that time had gotten larger and was surrounded by white. Interview with the supervisor on 9/11/08 at 3:10 PM noted that she did not call the doctor, and did not obtain any treatment orders for the area. The supervisor noted that she thought everyone knew about the issues.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or Connecticut General Statutes 19a-550 and/or (j) Director of Nurses (2).

2. Based on clinical record review, review of facility investigation, and facility staff interviews for the one of three sampled residents who alleged mistreatment (R #307), the facility failed to ensure that the resident was treated appropriately by staff. The findings included:
   a. Resident #307's diagnoses included stroke with left hemiparesis, and depression. The nursing admission assessment dated 8/27/08 identified that the resident was alert, and oriented to person, place, and time. The assessment noted that the resident required staff assistance for bathing and had multiple ecchymotic areas, but none noted on the fingers. A social work note dated 8/27/08 noted the resident was alert and oriented. The care plans dated 8/27, and 8/29/08 identified problems that included new admission, self care deficit, and uncooperative related to providing therapeutic recreation preferences. Interventions included staff assist of one, and to respect the resident's rights to refuse (activity).
   Facility documentation dated 8/31/08 noted the resident had reported that NA #1 was rough while getting dressed, pushed the resident's hand away and the hand hit the side rail. A bruise to the right hand 5th finger was noted. Interview on 9/03/08 at 9:00AM with Resident #307 noted that NA #1 was rough while turning him/her, and as he/she went to put a hand up to tell NA #1 not to be so rough, NA #1 hit her hand back causing a bruise to the little finger. During interview on 9/04/08 at 11:53 AM, R#307 repeated the exact story and a bluish purple discoloration was noted on the 5th finger of the right hand. The resident remarked that's where she hit me, on the vein, it is better now.
   Interview on 9/05/08 at 10:35 AM with Resident #94 (R#307's alert and oriented roommate) noted that he/she heard Resident #307 keep saying "leave me alone, I want to rest", and NA #1 continued to provide morning care for the resident and get him/her out of bed. Resident #94 noted that he/she did not hear anything such as a slap or hit.
   During an interview with NA#1 on 9/04/08 at 1:45 PM, she noted that she was aware that if a resident refuses care, she should leave the resident and report to the nurse. NA#1 noted she had to provide the care for the resident and get him/her up for physical therapy and that she must get every resident up. In a sworn statement, NA#1 indicated that she did not hit the resident and tried to calm the resident down when the resident raised his/her hand to the NA. An assessment of the resident by the psychiatric APRN on 9/8/08 identified that the resident was alert and oriented times three. The assessment identified that the resident related the feeling that NA #1 was annoyed with requests for assistance. The resident had a

FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

history of becoming "nasty" and had an irritable side when pushed into someone else's routine, not his/hers. The assessment concludes that "it is very important to this patient that he/she feels he/she is in control, and that we follow (the patient's) agenda-not that he/she follows staff's".

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or Connecticut General Statutes 19a-550 and/or (j) Director of Nurses (2).

3. Based on clinical record review and facility staff interview for one of three residents in survey sample who complained that staff had not treated them with respect/dignity (R #300), the facility failed to ensure that the resident's were treated with dignity and respect for their wishes. The findings included:
   a. Resident #300's diagnoses included above the knee amputation. An admission assessment dated 8/26/08 identified the resident was alert and oriented, and required two staff assistance for transfer/ toileting. During interview on 9/3/08 at 8:15 AM, the resident noted that he/she had requested to be taken to the bathroom over the weekend and that the nurse aide refused and would only provide a bedpan instead of taking him/her to the bathroom. The resident noted he/she was left on the bedpan for greater than one half hour before a different nurse aide took the resident off. During removal of the bedpan, urine spilled on the bed linen. The nurse aide was not going to change the linen until the resident insisted the linen was changed. Interview on 9/04/08 at approximately 9:50 AM with the DNS noted she was unaware of the issue. She noted that although staff may have been busy, the resident's request should have been followed (to toilet).

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D).

4. Based on review of facility documentation and interviews, the facility failed to respond to repeated Resident Council complaints regarding cold food. The findings include:
   a. Resident Council Minutes dated 6/16/08 noted that the residents continue to have issues with food. The residents requested to hold a monthly Food Council meeting after the Resident Council Meeting. Resident Council minutes dated 7/21/08 noted the Food Council meetings will start as of 7/21/08 to address food concerns including cold food. Food Council meeting minutes dated 7/21/08 noted food is served cold. Facility response was the coming of a "Country Kitchen" in a couple of months with meals served directly from pans. Resident Council minutes dated 8/18/08 contained complaints that food continues to come cold, even the coffee. Interviews on September 2, and 3, 2008 at various times with Residents #143, #277, #300, #302, #304, and #310 noted the food continued to be served cold. Interview with the Resident Council President on 9/04/08 noted the residents continue to complain the food is cold. The facility was unable to provide documented evidence that the resident's complaints had been investigated/addressed or that measures had been implemented to improve the food delivery system to ensure resident's received warm food.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

5. Based on clinical record review, review of facility investigation, and facility staff interviews for the one of three sampled residents who alleged mistreatment (R #307), the facility failed to ensure that the resident's requests were honored regarding getting out of bed, bathing, and/or dressing. The findings included:
   a. Resident #307's diagnoses included stroke with left hemiparesis, and depression. The nursing admission assessment dated 8/27/08 identified that the resident was alert, and oriented to person, place, and time. The assessment noted that the resident required staff assistance for bathing and had multiple ecchymotic areas, but none noted on the fingers.
   A social work note dated 8/27/08 noted the resident was alert and oriented. The care plans dated 8/27, and 8/29/08 identified problems that included new admission, self care deficit, and uncooperative related to providing therapeutic recreation preferences. Interventions included staff assist of one, and to respect the resident's rights to refuse (activity).
   Facility documentation dated 8/31/08 noted the resident had reported that NA #1 was rough while getting dressed, pushed the resident's hand away and the hand hit the side rail. A bruise to the right hand 5th finger was noted.
   Interview on 9/03/08 at 9:00 AM with Resident #307 noted that NA #1 was rough while turning him/her, and as he/she went to put a hand up to tell NA #1 not to be so rough, NA #1 hit her hand back causing a bruise to the little finger.
   During interview on 9/04/08 at 11:53 AM, R #307 repeated the exact story and a bluish purple discoloration was noted on the 5th finger of the right hand. The resident remarked that's where she hit me, on the vein, it is better now.
   Interview on 9/05/08 at 10:35 AM with Resident #94 (R#307's alert and oriented roommate) noted that he/she heard Resident #307 keep saying "leave me alone, I want to rest", and NA #1 continued to provide morning care for the resident and get him/her out of bed. Resident #94 noted that he/she did not hear anything such as a slap or hit.
   During an interview with NA #1 on 9/04/08 at 1:45 PM, she noted that she was aware that if a resident refuses care, she should leave the resident and report to the nurse. NA #1 noted she had to provide the care for the resident and get him/her up for physical therapy and that she must get every resident up. In a sworn statement, NA #1 indicated that she did not hit the resident and tried to calm the resident down when the resident raised his/her hand to the NA.
   An assessment of the resident by the psychiatric APRN on 9/8/08 identified that the resident was alert and oriented times three. The assessment identified that the resident related the feeling that NA #1 was annoyed with requests for assistance. The resident had a history of becoming "nasty" and had an irritable side when pushed into someone else's routine, not his/hers. The assessment concludes that "it is very important to this patient that he/she feels he/she is in control, and that we follow (the patient's) agenda-not that he/she follows staff's".

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (r) Therapeutic recreation (1).

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

6. Based on observation, facility staff interview and clinical record review for one of three sampled residents review for activities (R #301), the facility failed to provide appropriate activities to meet the resident's needs. The findings included:
    a. Resident #301 was admitted to facility on 8/25/08 with diagnoses that included Cerebral Vascular Accident (CVA), dementia and aphasia. A resident activity assessment dated 8/25/08 identified that R #301 was unable to speak due to the CVA, but made brief eye contact and was lethargic. The resident's recreation goal was for the therapeutic recreation staff (TR) to visit two times per week to develop trust and rapport. The care plan (RCP) dated 8/25/08 identified that the resident was minimally responsive to stimuli and TR visits. Interventions included providing a variety of sensory stimuli (i.e. auditory, visual, tactile and olfactory). Observations on 9/2/08 and 9/3/08 noted the resident in bed most of the day without the benefit of any stimulation activities. During an interview and review of recreation documentation with the TR and the Therapeutic Recreation Director (TRD) on 9/4/08 at 12:00 noon they could not provide documented evidence that recreation provided the interventions identified in the resident's plan of care.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(H).

7. Based on clinical record reviews, staff interviews, and review of facility policies for five of eight sampled residents with pressure/non-pressure related wounds and/or surgical incisions (Residents #210, #299, #309, #312, #500, #501), the facility failed to complete comprehensive assessments of the resident's skin conditions, including surgical wounds, pressure sores and/or non-pressure sores on admission and/or at least weekly resulting in a finding of immediate jeopardy. For one of three sampled residents with incontinence (R#210), the facility failed to assess the resident's incontinence. The findings include:
    a. Resident #312 was admitted to the facility on 9/11/07 after sustaining a fall with a tibia-fibula fracture of the left ankle. The resident had an external fixation device applied to stabilize the fracture on 7/24/07. The resident was admitted to the hospital on 8/3/07 where he/she underwent removal of the fixation device and internal fixation repair of the fracture. The resident was transferred to another hospital on 8/17/07 for acute inpatient rehabilitation and discharged to the skilled nursing facility on 9/11/07 for further rehabilitation. The W-10 and discharge summary from the hospital dated 9/11/07 indicated the presence of a splint to the left lower extremity that was wrapped with an ace wrap and a left heel "abrasion" that was covered with a "Biatain" dressing. Admission physician telephone orders dated 9/11/07 failed to direct any treatment to the left heel or directions for removing/not removing the splint to the left leg. The admission nursing assessment dated 9/11/07 identified the presence of a splint made of cast material to the left lower extremity. The toes were warm to touch and circulation, sensation, and movement were positive. No further assessment of the skin was completed at that time. Nurse's notes dated 9/13/07 on the day shift indicated that sutures were present to the left outer ankle. The note indicated that there was a broken suture and an open area in the incision line. The note indicated that the issue was put on the board for APRN

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WERE IDENTIFIED

...ssment, the area was cleansed and a dressing applied. No further mention of the area was noted in the clinical record until 9/17/07 when the APRN first assessed the area. The APRN assessment noted that the left outer ankle suture site was draining, that the son reported that the sutures needed to come out (still in place from the August surgical repair), and that she was not sure where the bleeding was coming from. She noted that an ace wrap was in place over a soft partial cast, and that the resident was experiencing pain on a scale of 10/10 that would reduce to 8/10 after Tylenol (the only pain medication ordered for the resident). The APRN then faxed written recommendations to the attending physician who had not yet visited/assessed the resident at the facility. The recommendations included:

1. Alleve twice a day for pain
2. Obtain x-ray of the left ankle/tibia/fibula.
3. Possibly have nursing or APRN unwrap Kling, clean and inspect wound to identify site of bleeding.
4. Remove as many sutures as possible.
5. Questionably have APRN check resident's PT/INR with machine approved by medical board (had not had PT/INR and was on Coumadin)

The physician failed to respond to the fax request.
On 9/20/07, at 8 AM, the resident went for a consult with a local orthopedist. Review of the acute care record noted that from the physician's office, the resident was sent directly to the hospital and admitted with diagnoses of osteomyelitis of the left lower extremity, sepsis (positive blood cultures were obtained on admission for staph aureus), and dehydration with a BUN of 65. The resident underwent immediate open amputation of the left leg below the knee. Interview and review of the clinical record with the DNS and Unit Manager on 9/5/08 at 8 AM failed to provide evidence that the resident's splint had been removed for complete assessment of the wounds. The unit manager, who had completed the admission body/skin assessment, identified that the splint had not been removed to inspect the skin underneath.
Resident #501 was admitted to the facility on 9/5/08 after hospitalization for a cholecystectomy with placement and retention of a Jackson-Pratt drain to the abdominal wound.

a. Resident #501's hospital discharge summary dated 9/5/08 identified that although the skin was intact, the resident had a "deep tissue injury" to the sacrum with some excoriation and the beginning of a sacral pressure ulcer. It indicated the hospital had been treating the area with Criticaid. Admission physician orders dated 9/5/08 directed the application of "Enzo zinc" ointment every shift and as needed after incontinent care. The nursing admission assessment dated 9/5/08 indicated that the upper buttocks were "excoriated". No further description of the area was noted. A skin condition report for non-pressure ulcer skin conditions dated 9/5/08 indicated the presence of "excoriation" and reddening of the buttocks. The Braden Scale assessment for pressure ulcer risk had not been completed as of 9/11/08 (6 days post admission). On 9/8/08, the Physician Assistant saw the resident and

documented the resident was incontinent of stool and that the buttocks were "discolored and excoriated". She ordered Exuderm dressing for the area. No further assessments of the area were noted in the clinical record. Observations with the ADNS and Unit Manager on 9/11/08 at 1:55 PM noted the resident seated in a wheelchair with a small foam cushion (less than 3 inch thick) in the wheelchair covered by a soaker pad. The resident was transferred to bed and a large hydrocolloid dressing was noted partially adhered to the left upper buttock. When the dressing was removed, 2 long (approximately 1-1 ½ inches long by ½ inch wide) open areas were noted on the left upper buttock. The open areas were dark red in color. The resident's entire sacral/coccyx/upper buttock area was a deep purple to black color and the perimeter of the area on the left buttock contained fragile skin with small openings. When asked if the area was an excoriation, the ADNS and Unit Manager noted that the area was a large, unstageable pressure ulcer, and that they could not determine how deep it might be at that point. Review of the clinical record failed to provide evidence that the unstageable pressure sore had been identified as such on admission or subsequently, that a detailed description/assessment of the area had been made/documented by the PA or nursing staff.

The ADNS noted at 3:45 PM that she was not made aware of the wound/area and had not included it in her wound rounds this week (9/10/08) because the area had been inappropriately identified as an excoriation and not a deep tissue injury/unstageable pressure sore.

b. Resident #501's physician orders on admission (9/5/08) failed to direct dressing changes for the Jackson-Pratt (JP) wound site and/or any surgical wounds. The admission nursing skin assessment identified only "surg site with JP drain". No other description/assessment of the area/incision was noted in the clinical record. The PA visited the resident on 9/8/08 and noted an abdominal dressing with serosanguinous drainage present. The note failed to describe what was under the dressing, the presence of sutures or an assessment of the drain insertion site. The plan noted was to change the dressing three times a day (every shift).

The treatment kardex failed to identify any treatments/dressing changes to the abdominal incision/JP drain site from 9/5/08 through 9/8/08 on the 3-11 PM shift when an entry directed a dry sterile dressing change to the abdomen every shift. Observation on 9/11/08 at 1:55 PM with the ADNS and Unit Manager noted a 4 by 4 dressing over the JP drain tubing that contained several layers. The under layers contained visible drainage, most of it dry. No date was noted on the dressing to indicate when it was last changed. The resident noted at that time that the last time it had been changed was about 2 days ago. Upon removal of the dressing by the Unit Manager, a large suture was noted holding the JP drain in place. The puncture wound containing the JP drain was reddened around the perimeter and yellowish, serosanguinous drainage was present on the old dressings and around the tube. The suture site was also reddened. The PA was asked to evaluate the incision site and stated that it looked ok but to "keep an eye

on it". Several other incision sites that were healed/scabbed were present in the upper right quadrant of the abdomen; none were documented on the admission skin assessment.

c. Resident #309 was admitted to the facility on 8/29/08. He/she was hospitalized with diagnoses that included failure to thrive, anasarca, dehydration, diabetes, and venous insufficiency. The inter-agency referral (W-10) and hospital discharge summary indicated non-pressure ulcers on the left heel and right calf. Treatment directions indicated that both lower extremities were to be treated with Maxsorb Ag dressings daily along with leg elevation.
Admission physician orders dated 8/29/08 failed to direct any treatments to the lower extremities except for the application of Ammonium Lactate 12% to both feet twice a day for 2 weeks. The admission nursing assessment indicated the presence of a thick crust to both lower extremities front and back and an area on the right posterior calf that was crusted with drainage. No measurements or other descriptions of the area were indicated. No further assessments/descriptions of the legs were noted in the clinical record until the PA assessed the resident on 9/8/08. The PA assessment noted only the presence of chronic hyperpigmentation and dry, thick skin to the lower extremities; unable to palpate pedal pulses. Orders were written at that time to treat the right lower extremity with Alginate and a non-adherent dressing daily and to apply Aquaphor to both lower extremities every shift. No descriptions/assessments of the lower extremities were noted in the clinical record.
Observations on 9/11/08 at 1:40 PM noted the resident seated at the side of the bed with both legs dangling and without elevation. The resident's spouse was present. Both legs were edematous and the skin was thick, crusty, and splitting in some areas. An undated Kling wrap was noted on the right leg just above the ankle. When the resident pulled up the pant legs, a large (greater than ½ dollar sized), red open area was noted below the right knee that was not covered by a dressing. Dry drainage was noted down the leg to just above the ankle area dressing. The resident noted it had been oozing "like mad". The resident noted and spouse confirmed that the last time the right lower extremity dressing had been changed was the "night before last". The resident indicated that he/she had asked the nurse to change the dressing, but the nurse failed to do so.
The ADNS attempted to remove the dressing, but the dressing was firmly adhered to the skin. After soaking off the gauze covering the wound, a large, raised, white, macerated ulcer area was noted on the back of the right lower leg just above the ankle. The ADNS noted that she had not assessed the areas prior to this time and would call the physician for orders to treat the new open area.
The weekly skin assessment was reviewed with the ADNS and noted that the 9/3/08 assessment was signed, but lacked any information/assessment of the skin. The 9/10/08 assessment was unsigned and blank. No assessments or accurate descriptions of the lower extremities and/or wounds could be found in the clinical record.

FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

d. Resident #500 was admitted to the facility on 8/29/08 after hospitalization for osteomyelitis. Other diagnoses included end stage renal failure requiring hemodialysis. The hospital discharge summary identified the presence of a "skin tear" measuring 1.5 by 1 cm on the right sacrum. A physician note included with the hospital discharge summary dated 8/26/08 identified the presence of a stage II pressure sore of the sacrum and noted that a wound consult was ordered (the wound consult was not present on the record from the hospital). Admission physician orders dated 8/29/08 directed skin treatment to buttock with "TAO with Telfa dressing daily". The admission nursing assessment dated 8/29/08 identified the presence of a 1 by 1 cm "skin tear" and indicated the location was on the right upper buttock/sacral area. A non-pressure sore skin condition report indicated the presence of a 1 by 1 cm "skin tear" on the right upper buttock on 8/29/08. Although a date of 9/5/08 was entered on the form indicating a re-assessment was due on that date, no further assessment was documented. The treatment kardex for September 2008 was reviewed and noted that the treatment had been circled indicating it was not done from 9/4-9/10/08. The reason for lack of treatment was not documented on either the kardex or in the nurse's notes. Observations with the ADNS on 9/11/08 at 1:40 PM noted a quarter sized circular wound on the right upper sacrum that was covered with pink, fragile tissue. The surrounding skin was noted to be dark red in color. The resident noted at the time that the area still hurt although hurt less than before. The resident also noted that the dressing that had been being applied would not stay on and no one had tried applying anything else. No dressing was present on the wound and the resident noted that no other treatments had been applied. The ADNS noted at that time that the area was a pressure sore that was fragile and required ongoing treatment. She further noted that although she was the wound nurse, she had not been notified of the wound because it had been classified as a skin tear. Review of the clinical record failed to provide evidence that the physician was notified of the treatment failure, that another form of protection/treatment had been initiated, that the area had been assessed from admission on 8/29/08 through 9/11/08 (13 days), or that the area had been appropriately identified as a pressure sore and not a skin tear. Subsequent to surveyor inquiry, a skin assessment on 9/11/08 identified an 8 by 5 cm healed wound and a treatment order for protection was added.

e. Resident #299 was admitted to the facility on 8/18/08 with diagnoses that included colon resection/ileostomy. The resident was noted to have two stage two pressure sores on admission; one on the right buttock and one on the left buttock. Both areas were documented as healed by 8/26/08. Interview and review of the resident's weekly skin assessments with the ADNS on 9/11/08 at 1 PM failed to provide evidence that the assessment due on 9/5/08 had been completed. No documented skin assessment had been completed since 8/29/08 (14 days).

f. Resident #210's diagnoses included compression fracture, cerebral vascular accident,

and Parkinson's disease. A minimum data assessment (MDS) dated 6/13/08, identified the resident had short-term memory problems, required extensive assistance for transfers and ambulation, was frequently incontinent of bladder, and was on a toileting schedule. A urinary incontinence assessment and evaluation dated 3/11/08 indicated R #210 was incontinent and although the three-day pattern assessment was complete, the daily progress section was blank. An interview with RN #2 on 9/4/08 at 2:00 PM indicated an evaluation of the three-day pattern assessment should have been completed in the daily progress section of the 3/11/08 urinary incontinence assessment, but was not completed. She further indicated R #210 was currently continent during waking hours with some incontinence at night and a bladder reassessment should have been completed in June 2008, but was not completed. Review of the facility policy and procedure, in part indicated a urinary incontinence assessment and evaluation is to be completed for all residents on admission and quarterly. The deficiencies noted above resulted in a finding of immediate jeopardy. The facility submitted an immediate plan of correction.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(H).

8. Based on clinical record reviews, and interviews for two of thirty-three sampled residents reviewed during the survey (R #24, #94), the facility failed to ensure that the assessments accurately reflected the resident's dressing ability and/or need for hemodialysis. The findings included:
   a. Resident #24's diagnoses included fractured femur, rheumatoid arthritis, and dementia. The initial assessment dated 1/29/08 and quarterly assessment dated 4/13/08 identified that the resident required extensive assistance with bed mobility, transfers, toileting and bathing, but was independent with dressing. The most recent quarterly assessment dated 7/27/08 identified that the resident required limited assistance for dressing. Interview and review of the clinical record on 9/05/08 at 9:52 AM with Unit Manager #2 noted that the resident had never been independent for dressing and that the previous assessments were inaccurate.
   b. Resident #94's diagnoses included end stage renal failure requiring hemodialysis. An admission assessment dated 8/10/08 failed to identify that the resident was receiving hemodialysis. The interagency transfer report dated 8/1/08 directed that the resident receive hemodialysis on Tuesday-Thursday-Saturday. Interview and review of the clinical record with the MDS Coordinator on 9/4/08 at 1:40 PM failed to provide evidence that the admission MDS assessment accurately reflected that the resident was receiving hemodialysis services.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(I).

9. Based on clinical record review, observations and interviews for the only sampled resident receiving hemodialysis (Resident #94), the facility failed to develop a comprehensive care plan that addressed the resident's needs related to monitoring and assessing the hemodialysis access device/double lumen permacath implanted in the right upper chest. The findings include:

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

a. Resident #94's diagnoses included end stage renal failure requiring hemodialysis. The care plans dated 8/1/08 failed to reflect the presence of any hemodialysis access devices. The Interagency patient referral report dated 8/1/08 identified that a permacath was in place to the right chest and that the resident was receiving hemodialysis three times a week. The nursing admission assessment dated 8/1/08 identified that the resident had a dialysis shunt in the right upper chest and was to receive dialysis Tuesday-Thursday-Saturday at 6 AM. Admission nursing note also identified that the resident was a dialysis patient with a permacath to the right chest wall and that the dressing was intact. Observations on 9/4/08 at 1:30 PM noted Resident #94 in the room with a double lumen permacath in the right upper chest with a dressing intact. Review of the clinical record with the MDS Coordinator on 9/4/07 at 1:40 PM failed to provide evidence that a comprehensive care plan had been developed to identify the type of access device the resident had and measures related to assessment and management of the device.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(I).

10. Based on clinical record reviews, observations, and interviews for three of thirty three sampled residents reviewed during survey (R #24, #78, #210), the facility failed to review and/or revise the care plans following a fall with history of falls, and/or failed to revise the resident care plan to reflect current bladder function, and/or failed to revise the care plan when the resident's mobility needs changed. The findings included:

a. Resident #24 was admitted on 1/22/08 with diagnoses that included fractured left femur, rheumatoid arthritis, and dementia. The nursing admission assessment dated 1/26/08 identified that the resident was oriented to person, and place, required staff assistance with ADL's, and had a fall and fracture in the last thirty days. The care plan dated 1/26/08 identified a problem related to risk for falls. Nurse's notes dated 2/09/08 at 2030 noted the resident was found sitting on the floor. Interview and review of the care plan on 9/05/08 at 9:52 AM with Unit Manager #2 noted that the care plan had not been reviewed and/or revised after the fall to reflect new interventions to prevent further falls.

b. Resident #78's diagnoses included a fractured elbow secondary to a fall on 3/4/08, chronic renal failure, hypertension, and schizophrenia. A minimum data assessment dated 8/31/08 identified that the resident required supervision with transfers, limited assistance with ambulation, and had experienced a fall with fracture in the previous 31-180 days. The care plan dated 6/17/08 indicated R #78 had two falls on 6/17/08. Interventions included a bed alarm and rehabilitation screen. A rehabilitation screen dated 6/19/08 indicated R #78 required a contact guard for transfer and ambulation. The care records (flow sheets for April/May/June 2008 indicated R #78 needed the assist of one person for transfers and locomotion. An observation on 9/4/08 at 1:30 PM identified R #78 sitting in a chair across from the bed, call bell attached to bed, not within R #78's reach. Further observation on 9/4/08 at 1:45 PM with RN #2 present identified R #78 ambulating independently into the bathroom. On 9/4/08 at 1:45 PM an interview with RN #1

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

indicated R #78 was currently walking independently and was not supervised or provided with a contact guard. Review of the care plan at that time with RN #1 failed to identify or provide evidence that the care plan was revised to address R #78's current mobility status/needs to prevent falls.

c. Resident #210's diagnoses included compression fracture, cerebral vascular accident, and Parkinson's disease. A minimum data assessment dated 6/13/08 identified the resident had short term memory problems, required extensive assistance for transfers and ambulation, was frequently incontinent of bladder, and was on a toileting schedule. The care plan dated 3/12/08 indicated R #210 required assistance for toileting and the care records for July-August 2008 indicated R #210 was continent. Review of the flow sheets dated 9/1/08 through 9/4/08 indicated R #210 was incontinent of large amounts of urine on the 11-7 Shift. An interview with RN #2 on 9/4/08 at 2:00 PM and review of the care plan failed to provide evidence that the care plan was revised to address R #210's incontinence.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) D... of Nurses (2) and/or (k) Nurse Supervisor (1).

1) ...ased on clinical record reviews, observations, review of facility policies, and interviews for 9 ...olved residents (R #24, #94, #30, #299, #309, #310, #312, #500, #501), the facility failed to ... and /or monitor the resident's hemodialysis access device, and/or failed to appropriately ... the resident's surgical and/or other wounds, including pressure sores upon admission and at ... weekly thereafter, and/or failed to ensure narcotic keys were kept safe and secure, and/or failed ... that medication labels were legible prior to attempting to administer the medication in ...ance with professional standards of practice. The findings include:

a. Resident #312 was admitted to the facility on 9/11/07 after sustaining a fall with a tibia-fibula fracture of the left ankle. The resident had an external fixation device applied to stabilize the fracture on 7/24/07. The resident was admitted to the hospital on 8/3/07 where he/she underwent removal of the fixation device and internal fixation repair of the fracture. The postoperative period was complicated by metabolic encephalopathy and deep vein thrombosis. The resident was transferred to another hospital on 8/17/07 for acute inpatient rehabilitation and discharged to the skilled nursing facility on 9/11/07 for further rehabilitation. The W-10 and discharge summary from the hospital dated 9/11/07 indicated the presence of a splint to the left lower extremity that was wrapped with an ace wrap and a left heel "abrasion" that was covered with a "Biatain" dressing. Admission physician telephone orders dated 9/11/07 failed to direct any treatment to the left heel or directions for removing/not removing the splint to the left leg. The admission nursing assessment dated 9/11/07 identified the presence of a splint made of cast material to the left lower extremity. The toes were warm to touch and circulation, sensation, and movement were positive. No further assessment of the skin was completed at that time. Nurse's notes dated 9/13/07 on the day shift indicated that sutures were present to the left outer ankle. The note indicated that there was a broken suture and an open area in the incision line. The note indicated that the issue was put on the board for APRN

assessment, the area was cleansed and a dressing applied. The physician was not notified and no treatment orders obtained at that time. No further mention of the area was noted in the clinical record until 9/17/07 when the APRN first assessed the area. The APRN assessment noted that the left outer ankle suture site was draining, that the son reported that the sutures needed to come out (still in place from the August surgical repair), and that she was not sure where the bleeding was coming from. She noted that an ace wrap was in place over a soft partial cast, and that the resident was experiencing pain on a scale of 10/10 that would reduce to 8/10 after Tylenol (the only pain medication ordered for the resident). The APRN then faxed written recommendations to the attending physician who had not yet visited/assessed the resident at the facility. The recommendations included:

1. Alleve twice a day for pain
2. Obtain x-ray of the left ankle/tibia/fibula.
3. Possibly have nursing or APRN unwrap Kling, clean and inspect wound to identify site of bleeding.
4. Remove as many sutures as possible.
5. Questionably have APRN check resident's PT/INR with machine approved by medical board (had not had PT/INR and was on Coumadin)

No phone call was documented and the physician failed to respond to the fax request. On 9/17/07 at 4 PM the resident's blood sugar was noted to be 356 mg/dl. Coverage was administered as ordered with 10 units of Regular Insulin. A blood sugar recheck at 8 PM noted a blood sugar of 400 mg/dl. No nurse ' s note was documented for the 3-11 PM shift, however physician orders at 8 PM directed to administer 12 units of regular insulin at that time and to obtain labs including CBC, chemistry, and urine for culture and sensitivity. No vital signs were documented. No night shift note was present in the clinical record. On 9/18/08 the 7 AM-3 PM shift documented that the resident's appetite was poor. No vital signs were documented. The 3 -11 PM shift note indicated that the resident's urinalysis showed 2+ leukocytes and the report was "faxed" to the attending physician. On 9/19/07, at 4 PM, the resident was noted with a temperature of 102 degrees Farenheit and a blood sugar of 389 mg/dl. The physician was notified at that time of the temperature and the positive urinalysis report and ordered the administration of Cipro. Laboratory results reported to the facility on 9/19/07 were notable for a BUN of 56 (normal 6-25), Creatinine of 2.2 (normal 0.67-1.17), and a white count of 13.1 (normal 3.8-10.6). The abnormal laboratory results were faxed to the attending physician and no response or follow up call was noted in the clinical record or 24 hour reports. On 9/20/07, the resident's 6 AM blood sugar was 476; the physician was notified and regular insulin coverage ordered. No further assessment or vital signs were documented. At 8 AM, the resident went for a consult with a local orthopedist. Review of the acute care record noted that from the physician's office, the resident was sent directly to the hospital and admitted with diagnoses of osteomyelitis of the left lower extremity, sepsis (positive blood cultures were obtained on admission for staph aureus), and dehydration with a BUN of 65. The resident underwent immediate open amputation of the left leg below the knee. Interview and review of the clinical record with

the DNS and Unit Manager on 9/5/08 at 8 AM failed to provide evidence that the resident's splint had been removed for complete assessment of the wounds, and/or that the treatment to the left heel had been transcribed on admission as per the W-10. The unit manager, who had completed the admission body/skin assessment, identified that the splint had not been removed to inspect the skin underneath. Subsequent to surveyor inquiry, the DNS found a paper in her desk dated 9/21/07 by the evening supervisor that noted she had removed the splint and dressings on 9/17/07. The note indicated that an open area in suture line of the ankle appeared to be the source of bleeding and that the resident had a 4 by 5 cm area of dark eschar on the left heel that the resident ' s son reported at that time had gotten larger and was surrounded by white. Interview with the supervisor on 9/11/08 at 3:10 PM noted that she did not call the doctor, did not chart the observation/assessment in the resident's chart, and did not obtain any treatment orders for the area. The supervisor noted that she thought everyone knew about the issues and that she thought the floor nurse (agency) who was present during the assessment, would do the documentation. According to the American Nurses' Association Standards of Nursing Practice - The collection of data about the health status of the client / patient is systematic and continuous. The data are accessible, communicated and recorded.

b. Resident # 94's diagnoses included end stage renal failure requiring hemodialysis. Interview and review of the clinical record with the MDS coordinator on 9/4/08 at 1:40pm failed to identify or provide evidence that the resident's hemodialysis double lumen permacath protruding from the chest, was assessed and/or monitored in accordance with professional standards of practice. Review of the facility policy and procedure for residents receiving hemodialysis directed the staff to provide ongoing assessments of the access site every shift for pain, infection, fever, bleeding and dislodgment.

c. Observation on 9/03/08 at 6:20 AM noted LPN#10 administering medications to Resident #30. LPN#10 was noted to put the narcotic keys into the top drawer of the medication cart. Interview and observation of the narcotic keys at 6:52 AM with LPN#10 noted the narcotic keys were still in the medication cart top drawer. Interview with LPN#10 at that time noted she was aware the narcotic keys should be carried with her at all times. She further noted that she had found them in the drawer when she came on duty at the start of her shift. Review of facility policy for controlled substances directed the keys to the controlled substance drawer or compartment of each mobile cart shall be separated from the keys to the other locking devices of that cart and shall be carried personally by the Nurse responsible for the controlled substance audit during each nursing shift.

d. Resident #310 was admitted 8/08/08 with diagnoses that included COPD, spinal stenosis, T12 fracture, osteoporosis, and rheumatoid arthritis on steroids. The initial assessment dated 8/15/08 identified that the resident was without cognitive impairment, required extensive staff assistance for ADL, and had skin tears or cuts other than surgery. The care plan dated 9/01/08 noted a problem related to a skin tear to the right lower extremity from putting on socks. Interventions included triple antibiotic ointment and dressing until healed. Observation on 9/04/08 at 11:30 AM noted a dressing to the lower extremity. The dressing was noted to lack a date and signature. Observation at 11:33 AM with the Charge Nurse noted the dressing lacked a date and signature and should have one. During interview and

EXHIBIT A

review of facility policy on 9/05/08 at approximately 9:00 AM and 1:00 PM with the DNS noted the facility policy for dressing change does not include dressings are to be dated and signed but the policy will be revised. According to

e. Resident #24's diagnoses included fractured femur, rheumatoid arthritis, and dementia. The quarterly assessment dated 7/27/08 identified that the resident had some cognitive impairment, and required limited assistance for dressing. Physician order dated 8/13/08 directed Forteo 750 mcg/3ml pen 0.08 cc (20 mcg) subcutaneously (sc) daily.

a. Observation on 9/02/08 at 10:10 AM noted RN#1 attempting to administer the Forteo 750 mcg/3ml-0.8 cc (20mg). The label was not readable. Following surveyor intervention, RN #1 stopped administering the medication. Interview with the RN #1 at that time noted she was not able to read the label dose.

b. On 9/02/08 at 10:10 AM during a second interview, the Unit Manager #2 noted the label (on the Forteo) was unreadable, she had not removed it from the med refrigerator and the medication was expired. Readable label directions directed for the medication to be thrown away 28 days after first use. The medication was started on 7/24/08, and should have been discarded as of 8/21/08.

According to Standards for Long Term Care 2007, Joint Commission, A standardized method for labeling all medications will minimize errors. Additionally, any time one or more medications or solutions are prepared but are not administered immediately, the medication container must be labeled. The label, in part should include the following; the residents name, resident location, directions for use and/or cautionary statements.

f. Resident #500 was admitted to the facility on 8/29/08 after hospitalization for osteomyelitis. Other diagnoses included end stage renal failure requiring hemodialysis. The hospital discharge summary identified the presence of a "skin tear" measuring 1.5 by 1 cm on the right sacrum. A physician note included with the hospital discharge summary dated 8/26/08 identified the presence of a stage II pressure sore of the sacrum and noted that a wound consult was ordered (the wound consult was not present on the record from the hospital). Admission physician orders dated 8/29/08 directed skin treatment to buttock with "TAO with Telfa dressing daily". The admission nursing assessment dated 8/29/08 identified the presence of a 1 by 1 cm "skin tear" and indicated the location was on the right upper buttock/sacral area. A non-pressure sore skin condition report indicated the presence of a 1 by 1 cm "skin tear" on the right upper buttock on 8/29/08. Although a date of 9/5/08 was entered on the form indicating a re-assessment was due on that date, no further assessment was documented. The treatment kardex for September 2008 was reviewed and noted that the treatment had been circled indicating it was not done from 9/4-9/10/08. The reason for lack of treatment was not documented on either the kardex or in the nurse's notes. Observations with the ADNS on 9/11/08 at 1:40 PM noted a quarter sized circular wound on the right upper sacrum that was covered with pink, fragile tissue. The surrounding skin was noted to be dark red in color. The resident noted at the time that the area still hurt although hurt less than before. The resident also noted that the dressing that had been being applied would not stay on and no one had tried applying anything else. No dressing was present on the wound and the resident noted that no other treatments had been applied. The ADNS

noted at that time that the area was a pressure sore that was fragile and required ongoing treatment. She further noted that although she was the wound nurse, she had not been notified of the wound because it had been classified as a skin tear. Review of the clinical record failed to provide evidence that the area had been assessed from admission on 8/29/08 through 9/11/08 (13 days), or that the area had been appropriately identified as a pressure sore and not a skin tear.

g. Resident #501 was admitted to the facility on 9/5/08 after hospitalization for a cholecystectomy with placement and retention of a Jackson-Pratt drain to the abdominal wound.

   a. Resident #501's hospital discharge summary dated 9/5/08 identified that although he skin was intact, the resident had a "deep tissue injury" to the sacrum with some excoriation and the beginning of a sacral pressure ulcer. It indicated the hospital had been treating the area with Criticaid. Admission physician orders dated 9/5/08 directed the application of "Enzo zinc" ointment every shift and as needed after incontinent care. The nursing admission assessment dated 9/5/08 indicated that the upper buttocks were "excoriated". No further description of the area was noted. A skin condition report for non-pressure ulcer skin conditions dated 9/5/08 indicated the presence of "excoriation" and reddening of the buttocks. The Braden Scale assessment for pressure ulcer risk had not been completed as of 9/11/08 (6 days post admission). On 9/8/08, the Physician Assistant saw the resident and documented the resident was incontinent of stool and that the buttocks were "discolored and excoriated". She ordered Exuderm dressing for the area. No further assessments of the area were noted in the clinical record. Observations with the ADNS and Unit Manager on 9/11/08 at 1:55 PM noted the resident seated in a wheelchair with a small foam cushion (less than 3 inch thick) in the wheelchair covered by a soaker pad. The resident was transferred to bed and a large hydrocolloid dressing was noted partially adhered to the left upper buttock. When the dressing was removed, 2 long (approximately 1-1 ½ inches long by ½ inch wide) open areas were noted on the left upper buttock. The open areas were dark red in color. The resident's entire sacral/coccyx/upper buttock area was a deep purple to black color and the perimeter of the area on the left buttock contained fragile skin with small openings. When asked if the area was an excoriation, the ADNS and Unit Manager noted that the area was a large, unstageable pressure ulcer, and that they could not determine how deep it might be at that point. Review of the clinical record failed to provide evidence that the unstageable pressure sore had been identified as such on admission or subsequently, that a detailed description/assessment of the area had been made/documented by the PA or nursing staff, or that appropriate pressure relieving devices had been initiated for the bed or chair. Subsequent to surveyor inquiry, the ADNS noted at 3:45 PM that a specialty alternating air mattress was being delivered at 5:30 PM that day and an appointment had been made for a consult with the wound care clinic for advice on treatments. She also indicated that physical therapy would evaluate the resident for a pressure relieving cushion for the wheelchair. She noted that she was not made aware of the wound/area and had not included it in her wound

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rounds this week (9/10/08) because the area had been inappropriately identified as an excoriation and not a deep tissue injury/unstageable pressure sore.

b. Resident #501's physician orders on admission (9/5/08) failed to direct dressing changes for the Jackson-Pratt (JP) wound site and/or any surgical wounds. The admission nursing skin assessment identified only "surg site with JP drain". No other description/assessment of the area/incision was noted in the clinical record. The PA visited the resident on 9/8/08 and noted an abdominal dressing with serosanguinous drainage present. The note failed to describe what was under the dressing, the presence of sutures or an assessment of the drain insertion site. The plan noted was to change the dressing three times a day (every shift). The treatment kardex failed to identify any treatments/dressing changes to the abdominal incision/JP drain site from 9/5/08 through 9/8/08 on the 3-11 PM shift when an entry directed a dry sterile dressing change to the abdomen every shift. Review of the treatment kardex noted that the dressing changes for the time period of 9/8/08 through 9/11/08 (through the 11 PM - 7 AM shift) were documented as completed on only 3 of 10 occasions. On 2 occasions, the treatment was circled indicating that it had not been completed; the other 5 occasions were blank. No reason for the lack of treatment completion was noted on the kardex or in the nurse's notes. Observation on 9/11/08 at 1:55 PM with the ADNS and Unit Manager noted a 4 by 4 dressing over the JP drain tubing that contained several layers. The under layers contained visible drainage, most of it dry. No date was noted on the dressing to indicate when it was last changed. The resident noted at that time that the last time it had been changed was about 2 days ago. Upon removal of the dressing by the Unit Manager, a large suture was noted holding the JP drain in place. The puncture wound containing the JP drain was reddened around the perimeter and yellowish, serosanguinous drainage was present on the old dressings and around the tube. The suture site was also reddened. The PA was asked to evaluate the incision site and stated that it looked ok but to "keep an eye on it". Several other incision sites that were healed/scabbed were present in the upper right quadrant of the abdomen; none were documented on the admission skin assessment. Subsequent to surveyor inquiry, the facility investigated the neglect of the resident as evidenced by the lack of dressing changes to the surgical site. Interview with the DNS on 9/16/08 at 8:45 AM noted that the investigation identified that although some nurse's claimed to have completed the dressing change, but did not document the treatment, the 11 PM - 7 AM nurse had failed to complete the treatment as directed and that the nurse was terminated from employment.

h. Resident #309 was admitted to the facility on 8/29/08. He/she was hospitalized with diagnoses that included failure to thrive, anasarca, dehydration, diabetes, and venous insufficiency. The inter-agency referral (W-10) and hospital discharge summary indicated non-pressure ulcers on the left heel and right calf. Treatment directions indicated that both lower extremities were to be treated with Maxsorb Ag dressings daily along with leg elevation. Admission physician orders dated 8/29/08 failed to direct any treatments to the lower extremities except for the application of Ammonium Lactate 12% to both feet twice a day for 2 weeks. The admission nursing assessment indicated the presence of a thick crust

to both lower extremities front and back and an area on the right posterior calf that was crusted with drainage. No measurements or other descriptions of the area were indicated. No further assessments/descriptions of the legs were noted in the clinical record until the PA assessed the resident on 9/8/08. The PA assessment noted only the presence of chronic hyperpigmentation and dry, thick skin to the lower extremities; unable to palpate pedal pulses. Also noted was chronic venous insufficiency, and peripheral vascular disease. Orders were written at that time to treat the right lower extremity with Alginate and a non-adherent dressing daily and to apply Aquaphor to both lower extremities every shift. No descriptions/assessments of the lower extremities were noted in the clinical record. Observations on 9/11/08 at 1:40 PM noted the resident seated at the side of the bed with both legs dangling and without elevation. The resident ' s spouse was present. Both legs were edematous and the skin was thick, crusty, and splitting in some areas. An undated Kling wrap was noted on the right leg just above the ankle. When the resident pulled up the pant legs, a large (greater than ½ dollar sized), red open area was noted below the right knee that was not covered by a dressing. Dry drainage was noted down the leg to just above the ankle area dressing. The resident noted it had been oozing " like mad " . The resident noted and spouse confirmed that the last time the right lower extremity dressing had been changed was the " night before last " . The resident indicated that he/she had asked the nurse to change the dressing, but the nurse failed to do so. The ADNS attempted to remove the dressing, but the dressing was firmly adhered to the skin. After soaking off the gauze covering the wound, a large, raised, white, macerated ulcer area was noted on the back of the right lower leg just above the ankle. The resident noted that the lotion helps but had not been applied since "yesterday morning". The ADNS noted that she had not assessed the areas prior to this time and would call the physician for orders to treat the new open area. Review of the treatment kardex noted that the Alginate dressing changes had been signed off as completed on 9/8, 9, and 10/08 during the 7 AM-3 PM shift. The Aquaphor ointment had been signed as completed on 6 of 11 occasions with the other 5 occasions remaining blank. The weekly skin assessment was reviewed with the ADNS and noted that the 9/3/08 assessment was signed, but lacked any information/assessment of the skin. The 9/10/08 assessment was unsigned and blank. No assessments or accurate descriptions of the lower extremities and/or wounds could be found in the clinical record. Subsequent to surveyor inquiry, an investigation was conducted by the facility into the resident's allegation of neglect as evidenced by lack of treatment to the legs and/or wounds. Interview on 9/16/08 at 8:45 AM with the DNS noted that she had verified that the resident asked the nurse to change the dressing, but the nurse had not done so.

i. Resident #299 was admitted to the facility on 8/18/08 with diagnoses that included colon resection/ileostomy. The resident was noted to have two stage two pressure sores on admission; one on the right buttock and one on the left buttock. Both areas were documented as healed by 8/26/08. Interview and review of the resident ' s weekly skin assessments with the ADNS on 9/11/08 at 1 PM failed to provide evidence that the assessment due on 9/5/08 had been completed. No documented skin assessment had been completed since 8/29/08 (14 days). According to The Guideline for Prevention and Management of Pressure Ulcers 2003 edition, pressure ulcers are to be assessed and

monitored at each dressing change, reassessed and measured at least weekly, including description of location, tissue type, size tunneling, exudates (amount, type, character, and odor), presence/absence of infection., wound edges, stage, periwound skin, pain, and adherence to prevention and treatment. According to Fundamentals of Nursing, The Art and Science of Nursing Care, Fourth Edition, 2001, page 904-905, Wounds are assessed by inspection (sight and smell) and palpation for appearance, drainage, and pain. Included in the assessment are sutures, any drains or tubes, and manifestations of complications. Assess for the approximation of wound edges, color of the wound and surrounding area, and signs of dehiscence or evisceration.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

12. Based on clinical record reviews, observations, and interviews for three of three sampled residents reviewed with non-pressure related wounds (R #312, #501, #309), the facility failed to assess, monitor and/or provide appropriate treatments to the surgical wounds and/or other skin conditions resulting in a finding of immediate jeopardy. The findings include:
    a. Resident #312 was admitted to the facility on 9/11/07 after sustaining a fall with a tibia-fibula fracture of the left ankle. The resident had an external fixation device applied to stabilize the fracture on 7/24/07. The resident was admitted to the hospital on 8/3/07 where he/she underwent removal of the fixation device and internal fixation repair of the fracture. The postoperative period was complicated by metabolic encephalopathy and deep vein thrombosis. The resident was transferred to another hospital on 8/17/07 for acute inpatient rehabilitation and discharged to the skilled nursing facility on 9/11/07 for further rehabilitation. The W-10 and discharge summary from the hospital dated 9/11/07 indicated the presence of a splint to the left lower extremity that was wrapped with an ace wrap and a left heel "abrasion" that was covered with a "Biatain" dressing. Admission physician telephone orders dated 9/11/07 failed to direct any treatment to the left heel or directions for removing/not removing the splint to the left leg. The admission nursing assessment dated 9/11/07 identified the presence of a splint made of cast material to the left lower extremity. The toes were warm to touch and circulation, sensation, and movement were positive. No further assessment of the skin was completed at that time. Nurse's notes dated 9/13/07 on the day shift indicated that sutures were present to the left outer ankle. The note indicated that there was a broken suture and an open area in the incision line. The note indicated that the issue was put on the board for APRN assessment, the area was cleansed and a dressing applied. The physician was not notified and no treatment orders obtained at that time. No further mention of the area was noted in the clinical record until 9/17/07 when the APRN first assessed the area. The APRN assessment noted that the left outer ankle suture site was draining, but a thorough assessment of the area was not documented in the note. The note reflected that the son reported that the sutures needed to come out (still in place from the August surgical repair), and that the APRN was not sure where the bleeding was coming from. She noted that an ace wrap was in place over a soft partial cast, and that the resident was experiencing pain on a scale of 10/10 that would reduce to 8/10 after Tylenol (the only

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pain medication ordered for the resident). The APRN then faxed written recommendations to the attending physician who had not yet visited/assessed the resident at the facility. The recommendations included:

1. Alleve twice a day for pain
2. Obtain x-ray of the left ankle/tibia/fibula.
3. Possibly have nursing or APRN unwrap Kling, clean and inspect wound to identify site of bleeding.
4. Remove as many sutures as possible.

No phone call was documented and the physician failed to respond to the fax request.
On 9/17/07 at 4 PM the resident's blood sugar was noted to be 356 mg/dl. Coverage was administered as ordered with 10 units of Regular Insulin. A blood sugar recheck at 8 PM noted a blood sugar of 400 mg/dl. No nurse's note was documented for the 3-11 PM shift, however physician orders at 8PM directed to administer 12 units of regular insulin at that time and to obtain labs including CBC, chemistry, and urine for culture and sensitivity. No vital signs were documented. No night shift note was present in the clinical record. On 9/18/08 the 7 AM-3 PM shift documented that the resident's appetite was poor. No vital signs were documented. The 3 -11 PM shift note indicated that the resident's urinalysis showed 2+ leukocytes and the report was "faxed" to the attending physician. On 9/19/07, at 4 PM, the resident was noted with a temperature of 102 degrees Farenheit and a blood sugar of 389 mg/dl. The physician was notified at that time of the temperature and the positive urinalysis report and ordered the administration of Cipro. Separate laboratory results reported to the facility on 9/19/07 were notable for a BUN of 56 (normal 6-25), Creatinine of 2.2 (normal 0.67-1.17), and a white count of 13.1 (normal 3.8-10.6). The abnormal laboratory results were faxed to the attending physician and no response or follow up call was noted in the clinical record or 24 hour reports. On 9/20/07, the resident's 6 AM blood sugar was 476; the physician was notified and regular insulin coverage ordered. No further assessment or vital signs were documented.
At 8 AM, the resident went for a consult with a local orthopedist. Review of the hospital record noted that from the physician's office, the resident was sent directly to the hospital and admitted with diagnoses of osteomyelitis of the left lower extremity, sepsis (positive blood cultures were obtained on admission for staph aureus), and dehydration with a BUN of 65. The resident underwent immediate open amputation of the left leg below the knee. Interview and review of the clinical record with the DNS and Unit Manager on 9/5/08 at 8 AM failed to provide evidence that the resident's splint had been removed for complete assessment of the wounds, and/or that the treatment to the left heel had been transcribed on admission as per the W-10, and/or that the physician had been notified when drainage and sutures along with an open area were noted on the left ankle on 9/13/07, or that the resident was assessed by the attending physician during his/her stay at the facility. The unit manager, who had completed the admission body/skin assessment, identified that the splint had not been removed to inspect the skin underneath. Subsequent to surveyor inquiry, the DNS found a paper in her desk dated 9/21/07 by the evening supervisor that noted she had removed the splint and dressings on 9/17/07. The note indicated that an open area in suture line of the ankle appeared to be the

source of bleeding and that the resident had a 4 by 5 cm area of dark eschar on the left heel that the resident's son reported at that time had "gotten larger and was surrounded by white". Interview with the supervisor on 9/11/08 at 3:10 PM noted that she did not call the doctor, did not chart the observation/assessment in the resident's chart, and did not obtain any treatment orders for the area. The supervisor noted that she thought everyone knew about the issues and that she thought the floor nurse (agency) who was present during the assessment, would do the documentation.

b. Resident #501 was admitted to the facility on 9/5/08 after hospitalization for a cholecystectomy with placement and retention of a Jackson-Pratt drain to the abdominal wound. Resident #501's physician orders on admission (9/5/08) failed to direct dressing changes for the Jackson-Pratt (JP) wound site and/or any surgical wounds. The admission nursing skin assessment identified only "surg site with JP drain". No other description/assessment of the area/incision was noted in the clinical record. The PA visited the resident on 9/8/08 and noted an abdominal dressing with serosanguinous drainage present. The note failed to describe what was under the dressing, the presence of sutures or an assessment of the drain insertion site. The plan noted was to change the dressing three times a day (every shift). The treatment kardex failed to identify any treatments/dressing changes to the abdominal incision/JP drain site from 9/5/08 through 9/8/08 on the 3-11 PM shift when an entry directed a dry sterile dressing change to the abdomen every shift. Review of the treatment kardex noted that the dressing changes for the time period of 9/8/08 through 9/11/08 (through the 11 PM - 7 AM shift) were documented as completed on only 3 of 10 occasions. On 2 occasions, the treatment was circled indicating that it had not been completed; the other 5 occasions were blank. No reason for the lack of treatment completion was noted on the kardex or in the nurse's notes. Observation on 9/11/08 at 1:55 PM with the ADNS and Unit Manager noted a 4 by 4 dressing over the JP drain tubing that contained several layers. The under layers contained visible drainage, most of it dry. No date was noted on the dressing to indicate when it was last changed. The resident noted at that time that the last time it had been changed "was about 2 days ago". Upon removal of the dressing by the Unit Manager, a large suture was noted holding the JP drain in place. The puncture wound containing the JP drain was reddened around the perimeter and yellowish, serosanguinous drainage was present on the old dressings and around the tube. The suture site was also reddened. The PA was asked to evaluate the incision site and stated that it looked ok but to "keep an eye on it". Several other incision sites that were healed/scabbed were present in the upper right quadrant of the abdomen; none were documented on the admission skin assessment. Subsequent to surveyor inquiry, the facility investigated the neglect of the resident as evidenced by the lack of dressing changes to the surgical site. Interview with the DNS on 9/16/08 at 8:45 AM noted that the investigation identified that although some nurses claimed to have completed the dressing change, but did not document the treatment, the 11 PM- 7AM nurse had failed to complete the treatment as directed and that the nurse was terminated from employment.

c. Resident #309 was admitted to the facility on 8/29/08. He/she was hospitalized with diagnoses that included failure to thrive, anasarca, dehydration, diabetes, and venous insufficiency. The inter-agency referral (W-10) and hospital discharge summary indicated

non-pressure ulcers on the left heel and right calf. Treatment directions indicated that both lower extremities were to be treated with Maxsorb Ag dressings daily along with leg elevation. Admission physician orders dated 8/29/08 failed to direct any treatments to the lower extremities except for the application of Ammonium Lactate 12% to both feet twice a day for 2 weeks. The admission nursing assessment indicated the presence of a thick crust to both lower extremities front and back and an area on the right posterior calf that was crusted with drainage. No measurements or other descriptions of the area were indicated. No further assessments/descriptions of the legs were noted in the clinical record until the PA assessed the resident on 9/8/08. The PA assessment noted only the presence of chronic hyperpigmentation and dry, thick skin to the lower extremities; unable to palpate pedal pulses. Also noted was chronic venous insufficiency, and peripheral vascular disease. Orders were written at that time to treat the right lower extremity with Alginate and a non-adherent dressing daily and to apply Aquaphor to both lower extremities every shift. No descriptions/assessments of the lower extremities were noted in the clinical record.

Observations on 9/11/08 at 1:40 PM noted the resident seated at the side of the bed with both legs dangling and without elevation. The resident's spouse was present. Both legs were edematous and the skin was thick, crusty, and splitting in some areas. An undated Kling wrap was noted on the right leg just above the ankle. When the resident pulled up the pant legs, a large (greater than ½ dollar sized), red open area was noted below the right knee that was not covered by a dressing. Dry drainage was noted down the leg to just above the ankle area dressing. The resident noted it had been oozing "like mad". The resident noted and spouse confirmed that the last time the right lower extremity dressing had been changed was the "night before last". The resident indicated that he/she had asked the nurse to change the dressing, but the nurse failed to do so.

The ADNS attempted to remove the dressing, but the dressing was firmly adhered to the skin. After soaking off the gauze covering the wound, a large, raised, white, macerated ulcer area was noted on the back of the right lower leg just above the ankle. The resident noted that the lotion helps but had not been applied since "yesterday morning". The ADNS noted that she had not assessed the areas prior to this time and would call the physician for orders to treat the new open area. Review of the treatment kardex noted that the Alginate dressing changes had been signed off as completed on September 8, 9, and 10, 2008 during the 7 AM-3 PM shift. The Aquaphor ointment had been signed as completed on 6 of 11 occasions with the other 5 occasions remaining blank.

The weekly skin assessment was reviewed with the ADNS and noted that the 9/3/08 assessment was signed, but lacked any information/assessment of the skin. The 9/10/08 assessment was unsigned and blank. No assessments or accurate descriptions of the lower extremities and/or wounds could be found in the clinical record. Subsequent to surveyor inquiry on 9/11/08, a skin assessment was conducted that documented the right knee open area measured 4 by 2.5 cm, and the area on the right calf was described as a white, draining area that measured 3 by 1.5 cm. Subsequent to surveyor inquiry, an investigation was conducted by the facility into the resident's allegation of neglect as evidenced by lack of treatment to the legs and/or wounds. Interview on 9/16/08 at 8:45 AM with the DNS noted that 7-3 shift nurse on 9/10/08 had started to do the treatment and got called out on an

emergency. She forgot to go back and complete the treatment. The investigation further identified that at approximately 12 AM on 9/11/08, the resident asked to have the dressing changed. Witnesses noted that the 11 PM – 7 AM charge nurse was informed by the nurse aide that the dressing needed changing. Interview with LPN #2 on 9/18/08 at 1:30 PM noted that she did not have time to change the dressing or apply the Aquaphor lotion to the resident's legs as ordered. She further noted that she did not report to the supervisor that she didn't have time for the treatments.

The deficiencies noted above resulted in a finding of immediate jeopardy. The facility submitted an immediate plan of correction.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(B).

13. Based on clinical record reviews, observations, and facility staff interviews for two of three sampled residents requiring assistance with activities of daily living (R #301, #134), the facility failed to provide appropriate nail care and/or mouth care assistance. The findings included:
    a. Resident #134's assessment dated 6/15/08 identified the resident was moderately cognitively impaired, and required assistance with activities of daily living. The nurse aide (NA) accountability and care program documentation (flow sheets) directed staff to assist the resident with dressing, and toileting and to provide personal hygiene. Observation on 9/2/08 at 9:00 AM noted that the resident had extremely long fingernails on both of his/her hands. Interview with the unit manager on 9/4/08 at 10:21 AM noted that she had observed the nails as needing care and would have someone take care of them.
    b. Resident #301 was admitted to facility on 8/25/08 with diagnoses that included Cerebral Vascular Accident (CVA), Dementia and Aphasia. A nursing assessment dated 8/25/08 identified that R #301 was aphasic, was an aspiration risk, utilized a multi podus boot and required mechanical (Marissa) lift for transfers with assistance of two staff. The resident care plan (RCP) dated 8/26/08 identified a problem with self-care deficit related to the resident's need for extensive assistance related to CVA and dementia. Interventions included provide items needed for care. Review of clinical nurse aide (NA) accountability and care program documentation noted that R#301 was dependent on staff for provision of personal hygiene. Observation on 9/3/08 at 7:30 AM noted the resident being fed breakfast by facility staff. At 9:00 AM, staff were providing morning hygiene as well as incontinent care. Continued observation of the resident failed to identify staff provision of mouth care. Interview and review of R #301's bedroom with the unit manager on 9/3/08 at 9:58 AM identified personal care products located in top draw of bedside table. Review of the products identified an unopened toothpaste, unopened (plastic sealed) toothbrush and original sealed unopened container of mouthwash. The unit manager indicated at that time, that although a mouth/tooth sponge type cleaning device would be appropriate for the resident, there was no evidence of its presence in the resident room at that time. Interview with the nursing staff (licensed and NA) with the unit manager at that time identified that mouth care had not been rendered. Interview with the nurse aide (assigned to resident) at

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

that time noted that she had not provided mouth care that morning, but would do so as soon as possible.

Resident # 301 was admitted to facility on 8/25/08 with diagnoses that included Cerebral Vascular Accident (CVA), dementia and aphasia. A nursing assessment dated 8/25/08 identified that R#301 was aphasic, was an aspiration risk, utilized a multi podus boot and required mechanical (Marissa) lift for transfers with assistance of two staff. It further identified that both heels had boggy, reddened areas that measured 1.03 x1.03 cm, a stage I pressure area on the right small toe that measured 3.5 x 4.0 cm, a right foot 2.0 x 2.3 CM fluid filled blister, the right great toe had a 2.x 3. cm reddened area, and a reddened, intact coccyx (old ulcer). The care plan dated 8/26/08 identified a problem with alteration in skin integrity related to a rash on the perineum. Interventions included providing gentle cleansing and applying medication as directed. Physician orders dated 8/26/08 directed to apply Lotrisone cream to fungal rash sacral/groin area twice a day topically for two weeks. Observation on 9/3/08 at 9:00 AM with the unit manager, noted the resident receiving morning care by two NA's. One NA was utilizing a basin of water and a wash cloth without a cleanser to wash the resident's face, upper body, both arms and torso. The Unit manager intervened before the NA began further care by providing the NA with a container of non-rinse peri-wash. The resident was noted to have an indwelling (in bladder) Foley catheter and had been incontinent of feces. The NA began to wash the groin/perineum area that was red and had two visible open areas. The NA was then observed to wipe the feces through the open areas. Interview with the Physician Assistant (PA) on 9/3/08 at 9:25 AM after evaluating R #301's open areas located on his/her perineum, she indicated that the area (near scrotum) measured 1.0 x1.0 CM and that the area closer to rectum measured 1.2 x 1.0 CM and was new. She further indicated that washing feces through impaired skin was not desirable because it could cause infections.

...ing is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) ... Nurses (2) and/or (m) Nursing Staff (2)(A).

...ed on clinical record reviews, observations, and interviews for five of eight sampled residents with pressure ulcers (R#301, 312, 500, 501, 299), the facility failed to ensure appropriate treatment ... promote healing and/or prevent further development of pressure ulcers, and/or failed to appropriately identify and treat pressure ulcers upon admission, and/or failed to re-assess the skin of ...dent's at risk for the development of pressure sores resulting in a finding of immediate jeopardy. ...e findings included:

a. Resident #501 was admitted to the facility on 9/5/08 after hospitalization for a cholecystectomy with placement and retention of a Jackson-Pratt drain to the abdominal wound. Resident #501's hospital discharge summary dated 9/5/08 identified that although the skin was intact, the resident had a "deep tissue injury" to the sacrum with some excoriation and the beginning of a sacral pressure ulcer. It indicated the hospital had been treating the area with Criticaid. Admission physician orders dated 9/5/08 directed the application of "Enzo zinc" ointment every shift and as needed after incontinent care. The nursing admission assessment dated 9/5/08 indicated that the upper buttocks were

"excoriated". No further description of the area was noted. A skin condition report for non-pressure ulcer skin conditions dated 9/5/08 indicated the presence of "excoriation" and reddening of the buttocks. The Braden Scale assessment for pressure ulcer risk (per facility policy to be done at the time of admission) had not been completed as of 9/11/08 (6 days post admission). On 9/8/08, the Physician Assistant saw the resident and documented the resident was incontinent of stool and that the buttocks were "discolored and excoriated". She ordered Exuderm dressing for the area. No further assessments of the area were noted in the clinical record. Observations with the ADNS and Unit Manager on 9/11/08 at 1:55 PM noted the resident seated in a wheelchair with a small foam cushion (less than 3 inch thick) in the wheelchair covered by a soaker pad. The resident was transferred to bed and a large hydrocolloid dressing was noted partially adhered to the left upper buttock. When the dressing was removed, 2 long (approximately 1-1 ½ inches long by ½ inch wide) open areas were noted on the left upper buttock. The open areas were dark red in color. The resident's entire sacral/coccyx/upper buttock area was a deep purple to black color and the perimeter of the area on the left buttock contained fragile skin with small openings. When asked if the area was an excoriation, the ADNS and Unit Manager noted that the area was a large, unstageable pressure ulcer, and that they could not determine how deep it might be at that point. Review of the clinical record failed to provide evidence that the unstageable pressure sore had been identified as such on admission or subsequently, that a detailed description/assessment of the area had been made/documented by the PA or nursing staff, or that appropriate pressure relieving devices had been initiated for the bed or chair.

Subsequent to surveyor inquiry, the ADNS noted at 3:45 PM that a specialty alternating air mattress was being delivered at 5:30PM that day and an appointment had been made for a consult with the wound care clinic for advice on treatments. She also indicated that physical therapy would evaluate the resident for a pressure relieving cushion for the wheelchair. She noted that she was not made aware of the wound/area and had not included it in her wound rounds this week (9/10/08) because the area had been inappropriately identified as an excoriation and not a deep tissue injury/unstageable pressure sore. A skin assessment documented on 9/11/08 identified the area as an unstageable pressure sore measuring 17 by 14 cm that was purple/dark red in color and macerated.

b. Resident #312 was admitted to the facility on 9/11/07 after sustaining a fall with a tibia-fibula fracture of the left ankle. The resident had an external fixation device applied to stabilize the fracture on 7/24/07. The resident was admitted to the hospital on 8/3/07 where he/she underwent removal of the fixation device and internal fixation repair of the fracture. The resident was transferred to another hospital on 8/17/07 for acute inpatient rehabilitation and discharged to the skilled nursing facility on 9/11/07 for further rehabilitation. The W-10 and discharge summary from the hospital dated 9/11/07 indicated the presence of a splint to the left lower extremity that was wrapped with an ace wrap and a left heel "abrasion" that was covered with a "Biatain" dressing. Admission physician telephone orders dated 9/11/07 failed to direct any treatment to the left heel. The admission nursing assessment dated 9/11/07 identified the presence of a splint made of cast

material to the left lower extremity. The toes were warm to touch and circulation, sensation, and movement were positive. No further assessment of the skin was completed at that time. On 9/17/07 the APRN first assessed the lower extremity. The APRN assessment noted that a left outer ankle suture site was draining. The note failed to provide evidence that the lower extremity was unwrapped to assess the skin under the splint. A request to remove the splint and assess the skin was faxed to the attending physician who had not yet visited the resident at the facility. The physician never responded and no attempts to reach the physician were documented. On 9/20/07, the resident went for a consult with a local orthopedist. Review of the acute care record noted that from the physician's office, the resident was sent directly to the hospital and admitted with diagnoses of osteomyelitis of the left lower extremity, sepsis (positive blood cultures were obtained on admission for staph aureus), and dehydration with a BUN of 65. The resident underwent immediate open amputation of the left leg below the knee. Interview and review of the clinical record with the DNS and Unit Manager on 9/5/08 at 8 AM failed to provide evidence that the resident's splint had been removed for complete assessment of the lower extremity, and/or that the treatment to the left heel had been transcribed on admission as per the W-10. The unit manager, who had completed the admission body/skin assessment, identified that the splint had not been removed to inspect the skin underneath. She was unable to provide any evidence that measures to alleviate pressure to the resident's left lower extremity had been implemented.

Subsequent to surveyor inquiry, the DNS found a paper in her desk dated 9/21/07 by the evening supervisor that noted she had removed the splint and dressings on 9/17/07 (6 days after admission). The note indicated that there was an open area in suture line of the ankle appeared to be the source of bleeding and that the resident had a 4 by 5 cm area of dark eschar on the left heel that the resident's son reported at that time had gotten larger and was surrounded by white. Interview with the supervisor on 9/11/08 at 3:10 PM noted that she did not call the doctor, did not chart the observation/assessment in the resident's chart, and did not obtain any treatment orders for the area. The supervisor noted that she thought everyone knew about the issues and that she thought the floor nurse (agency) who was present during the assessment, would do the documentation.

c. Resident #301 was admitted to facility on 8/25/08 with diagnoses that included Cerebral Vascular Accident (CVA), dementia and aphasia. A nursing assessment dated 8/25/08 identified that R #301 was aphasic, was an aspiration risk, utilized a multi podus boot and required mechanical (Marissa) lift for transfers with assistance of two staff. It further identified that both heels had boggy, reddened areas that measured 1.03 x1.03 cm, a stage I pressure area on the right small toe that measured 3.5 x 4.0 cm, a right foot 2.0 x 2.3 CM fluid filled blister, the right great toe had a 2.x 3. cm reddened area, and a reddened, intact coccyx (old ulcer). The care plan (RCP) dated 8/26/08 identified an alteration in skin integrity related to pressure ulcer located on the left Heel and Malleolus. Physician admission orders dated 8/25/08 directed the application of Multi-podus boots to right and left feet at all times, remove every shift for treatment and skin checks and daily hygiene, and to apply skin prep to left Malleolus and left heel every shift for seven days. Physician orders dated 8/25/08 directed that the left foot may use Stay Put heel protector until a

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Multi-podus boot is available. Observation on 9/3/08 at 8:50 AM with the unit manager identified that the resident was without the benefit of the left Stayput device and that the left foot was positioned directly upon the bed and under the right foot (with the multi-podus boot on). Interview and review of clinical record with the Unit manager at that time indicated that the resident required bilateral foot/heel protection at all times.

d. Resident #500 was admitted to the facility on 8/29/08 after hospitalization for osteomyelitis. Other diagnoses included end stage renal failure requiring hemodialysis. The hospital discharge summary identified the presence of a "skin tear" measuring 1.5 by 1 cm on the right sacrum. A physician note included with the hospital discharge summary dated 8/26/08 identified the presence of a stage II pressure sore of the sacrum and noted that a wound consult was ordered (the wound consult was not present on the record from the hospital). Admission physician orders dated 8/29/08 directed skin treatment to buttock with "TAO with Telfa dressing daily". The admission nursing assessment dated 8/29/08 identified the presence of a 1 by 1 cm "skin tear" and indicated the location was on the right upper buttock/sacral area. A non-pressure sore skin condition report indicated the presence of a 1 by 1 cm "skin tear" on the right upper buttock on 8/29/08. Although a date of 9/5/08 was entered on the form indicating a re-assessment was due on that date, no further assessment was documented. The treatment kardex for September 2008 was reviewed and noted that the treatment had been circled indicating it was not done from 9/4-9/10/08. The reason for lack of treatment was not documented on either the kardex or in the nurse's notes. Observations with the ADNS on 9/11/08 at 1:40 PM noted a quarter sized circular wound on the right upper sacrum that was covered with pink, fragile tissue. The surrounding skin was noted to be dark red in color. The resident, who was alert and oriented times three, noted at the time that the area still hurt although hurt less than before. The resident also noted that the dressing that had been being applied would not stay on and no one had tried applying anything else. No dressing was present on the wound and the resident noted that no other treatments had been applied. The ADNS noted at that time that the area was a pressure sore that was fragile and required ongoing treatment. She further noted that although she was the wound nurse, she had not been notified of the wound because it had been classified as a skin tear. Review of the clinical record failed to provide evidence that the physician was notified of the treatment failure, that another form of protection/treatment had been initiated, that the area had been assessed from admission on 8/29/08 through 9/11/08 (13 days), or that the area had been appropriately identified as a pressure sore and not a skin tear. Subsequent to surveyor inquiry, a skin assessment on 9/11/08 identified an 8 by 5 cm healed wound and a treatment order for protection was added.

e. Resident #299 was admitted to the facility on 8/18/08 with diagnoses that included colon resection/ileostomy. The resident was noted to have two stage two pressure sores on admission; one on the right buttock and one on the left buttock. Both areas were documented as healed by 8/26/08. Interview and review of the resident's weekly skin assessments with the ADNS on 9/11/08 at 1 PM failed to provide evidence that the assessment due on 9/5/08 had been completed. No documented skin assessment had been completed since 8/29/08 (14 days). Subsequent to surveyor inquiry, a skin assessment on

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

9/11/08 documented a right buttock recently healed pressure sore that was slightly red and measured 6 by 3 cm. The left buttock pressure sore was noted as a healed stage 3 that was scabbed and measured 1.5 by 1.0 cm.

The deficiencies noted above resulted in a finding of immediate jeopardy. The facility submitted an immediate plan of correction.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and Professional Services (1).

15. Based on clinical record review, and interview for 2 of 37 sampled residents (R #312, #501), the facility failed to ensure that the first assessment of the resident after admission was made by the attending physician in a timely manner. The findings include:
    a. Resident #501 was admitted to the facility on 9/5/08 after hospitalization for a cholecystectomy with placement and retention of a Jackson-Pratt drain to the abdominal wound. Resident #501's physician orders on admission (9/5/08) failed to direct dressing changes for the Jackson-Pratt (JP) wound site and/or any surgical wounds. The admission nursing skin assessment identified only "surg site with JP drain". No other description/assessment of the area/incision was noted in the clinical record. The PA visited the resident on 9/8/08 and noted an abdominal dressing with serosanguinous drainage present. The note failed to describe what was under the dressing, the presence of sutures or an assessment of the drain insertion site. Interview and review of the clinical record with the DNS on 9/18/08 at 2 PM failed to provide evidence that the resident's attending physician had visited the resident since admission (13 days). The history and physical and physician progress notes were blank and the admission orders remained unsigned.
    b. Resident #312 was admitted to the facility on 9/11/07 after sustaining a fall with a tibia-fibula fracture of the left ankle. The resident was transferred to the hospital on 9/20/07. The APRN assessment dated 9/17/07 noted that the left outer ankle suture site was draining, that the son reported that the sutures needed to come out (still in place from the August surgical repair), and that she was not sure where the bleeding was coming from. She noted that an ace wrap was in place over a soft partial cast, and that the resident was experiencing pain on a scale of 10/10 that would reduce to 8/10 after Tylenol (the only pain medication ordered for the resident). The APRN then faxed written recommendations to the attending physician who had not yet visited/assessed the resident at the facility. The recommendations included:
        1. Alleve twice a day for pain
        2. Obtain x-ray of the left ankle/tibia/fibula.
        3. Possibly have nursing or APRN unwrap Kling, clean and inspect wound to identify site of bleeding.
        4. Remove as many sutures as possible.
        5. Questionably have APRN check resident's PT/INR with machine approved by medical board (had not had PT/INR and was on Coumadin)

    No phone call was documented and the physician failed to respond to the fax request.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Interview and review of the clinical record with the DNS and Unit Manager on 9/5/08 at 8 AM failed to provide evidence that the attending physician had evaluated the resident while at the facility or responded to a faxed request on 9/17/07 to treat the resident's problems by the APRN.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2).

16. Based on observation and interview, the facility failed to ensure medications were stored to maintain the safety and integrity of the container and or label. The findings include:
    a. Observation on 9/02/08 at 9:40 AM of the 2 CD medication room refrigerator noted that the bottom shelf contained a moist towel, an insulin box that was moist and soft, and a vial of Forteo, which had a label that was unreadable. Interview with Unit Manager #2 at 9:45 AM noted she was unaware of the towel and the unreadable label, that there was water dripping inside, and that she would resolve the situation. At 10:10 AM RN #1was noted attempting to dispense the Forteo medication from the unreadable label bottle. Following surveyor intervention, RN #1 did not administer the medication.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (t) Infection Control (2).

17. Based on clinical record review, observations and interview for one of ten medication administration observations (R #68), the facility failed to ensure that soap and/or appropriate sanitizer was used to cleanse hands between residents during medication administration. The findings include:
    a. Resident #68's diagnoses included dementia, and cirrhosis. Observation on 9/02/08 at 10:05 AM noted Licensed Practical Nurse #1 administering oral medications to the resident. Although the she washed her hands with water after administering the medications, she failed to use soap or sanitize her hands between residents. Interview with LPN #1 at that time noted she was going to use gel sanitizer but there was none. Interview on 9/04/08 at 9:35 AM with the DNS noted she would expect soap or sanitizer to be used. Facility policy for hand washing directed for soap to be used when washing hands.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2).

18. Based on review of personnel files and interview for 4 of 5 nurse aide files reviewed, the facility failed to complete annual performance evaluations. The findings include:
    a. Nurse Aide #2's last performance evaluation was dated 5/1/03.
    b. Nurse Aide #3's last performance evaluation was dated 1/29/04.
    c. Nurse Aide #4's last performance evaluation was dated 2/13/04.
    d. Nurse Aide #5's last performance evaluation was dated 5/2/03.

Interview on 9/19/08 at 1:30 PM with the administrative assistant noted they were unable to locate

any other performance evaluations.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (h) Medical Director (2).

19. Based on clinical record reviews, observations and interviews, the medical director failed to ensure that problems related to late physician visits, physician responsiveness to facility calls, and/or lack of nursing assessments were addressed and plans implemented/monitored to correct the issues. The findings include:

a. Interview with the medical director on 9/4/08 at 11 AM identified that he was aware of and had reviewed the issues related to the care of R #312 after the resident was transferred to the hospital in 9/07 including the lack of nursing assessment of the resident, lack of physician visit in a timely manner, and lack of physician responsiveness to phone calls/faxes from nursing staff. Results of the survey identified ongoing issues with lack of resident assessment by nursing and physicians (please refer to deficiencies F272, 309, 314, 388). The facility was unable to provide evidence of a plan to monitor the care and services provided by nursing staff or physicians.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (o) Medical Records (2)(H).

20. Based on clinical record reviews, observations, and interviews for two sampled residents (R#312, #309), the physician failed to date admission orders and telephone orders when they were cosigned at some point after the resident's hospital transfer, and/or the physician failed to accurately complete a history and physical to reflect the current condition of the resident. The findings include:

a. Resident #312 was admitted to the facility on 9/11/07 after sustaining a fall with a tibia-fibula fracture of the left ankle. The resident was discharged to the hospital on 9/20/08. Interview and review of the clinical record with the unit manager and DNS on 9/5/08 at 8 AM failed to provide evidence that the physician had ever assessed the resident at the facility. Further review noted that the physician orders had been signed by another physician in the practice at some point after the resident's discharge, but the signature was not dated.

b. Resident #309 was admitted to the facility on 8/29/08. He/she was hospitalized with diagnoses that included failure to thrive, anasarca, dehydration, diabetes, and venous insufficiency. The inter-agency referral (W-10) and hospital discharge summary indicated non-pressure ulcers on the left heel and right calf. Treatment directions indicated that both lower extremities were to be treated with Maxsorb Ag dressings daily along with leg elevation. The admission nursing assessment dated 8/29/08 indicated the presence of a thick crust to both lower extremities front and back and an area on the right posterior calf that was crusted with drainage. Review of the attending physician's history and physical dated 8/30/08 with the DNS on 9/19/08 at 11 AM noted that the physician failed to completely fill out the resident's medical and social history, and diagnoses. Further review noted that although the resident had a significant skin condition of both lower extremities

EXHIBIT A

OLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

and an ulcer of the right calf, the physician failed to note any medical issues at all on the form.

wing is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) rator (3)(A) and/or (j) Director of Nurses (2).

on interviews, the facility failed to maintain a quality assessment and assurance committee at least quarterly to identify issues of concern and develop/implement appropriate plans of to correct identified quality deficiencies. The findings include:

a. Multiple interviews throughout the survey with the medical director, director of nursing and the administrator noted that although the nursing assessment issues identified in deficiencies F272, 309 and 314, had been identified by staff as problems, they were unable to provide evidence that a quality assurance committee examined the circumstances of the issues, investigated the root cause, or developed a plan to improve wound care and assessments. Although data/statistics related to infection control, accidents, and pressure sores were presented at quarterly medical staff meetings, the data was not utilized to develop plan and approaches for addressing the concerns.

EXHIBIT B
PAGE 1 OF 1

FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
  - Assessment of staff in carrying out their roles of administration, supervision and education.
  - Assessment of institution's compliance with federal/state laws and regulations.
  - Recommendations to institutional administration regarding staff performance.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Recommendation of staff changes based on observations and regulatory issues.
  - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
  - Promotes staff growth and accountability.
  - May present some inservices but primary function is to develop facility resources to function independently.
  - Educates staff regarding federal/state laws and regulations.